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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	03/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

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I 000	INITIAL COMMENTS A licensure survey was conducted from March 12, 2008 through March 14, 2008. A random sample of three clients was selected from a client population of six male clients with varying degrees of disabilities. The survey was completed using the fundamental survey process. The findings of this survey were based on observations at the group home and two day program, interview with day program staff, residential staff, and a review of the habilitation and administrative records to include the review of the facility incident management system.	I 000		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one of the three residents in the sample prescribed modified diet is monitored being quarterly by a dietitian. The finding includes: On March 13, 2008, interview direct care staff and review of records revealed that Resident #3 was prescribed a modified diet [1550 calorie, high fiber chopped]. Further review of the records revealed that the the nutritionist last monitoring visit was in September 1, 2007. There was no further evidence that this consultant was monitoring Client #3's modified diet in accordance with this regulatory requirement.	I 043	I 043 The consultant Nutritionist completes a quarterly follow up assessment. In the future the Facility will ensure that all reports are filed in the appropriate records in a timely manner. See attached Quarterly Nutritional assessments	4/7/08

2008 APR 11 P 1:46

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HEALTH REGULATION
ADMINISTRATION

Health Regulation Administration

Susan Sloan RN, BSN, MPA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: VP-Operations

(X6) DATE: 4/8/08

STATE FORM 6899 8TQ911 If continuation sheet 1 of 7

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I 054	3502.12 MEAL SERVICE / DINING AREAS Residents shall be provided training to develop eating skills and to use special eating equipment and utensils if such training is indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that Resident #1 was provided with adaptive plate as recommended by the interdisciplinary team to improve his independence in eating. The finding includes: Observation at the dinner meal on March 12, 2008 at approximately 5:40 PM revealed that Client #3 was eating a from a high sided scoop plate. Day program observation on March 13, 2008 at approximately 12:42 PM , revealed that Resident #3 sitting at the dining room table preparing to eat his lunch. The client meal was severed in a three partician plate. Interview with the QMRP at the group home revealed that client #3 is prescribed a high sided scoop plate at meals to assist him with his independent eating skills. According to the QMRP she purchased the prescribed adaptive plates and personally delivered the adaptive equipment to the day program for the client use during meals. Note: It should be further noted that the direct care staff assigned to table set up for the day program and food dispensing was employed at the client group homes in the evening.	I 054	I 054 A high-sided scoop plate has been delivered to the Day Program. Staff has been in serviced on adaptive equipment at the residential and day program sites. In the future the facility will ensure that the QMRP and Nurse visit the day program monthly to ensure program / medical needs are met. See attached 1.receipt for adaptive equipment from day program. 2.in service record	4/8/08

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I 058	Continued From page 2	I 058		
I 058	3502.16 MEAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review revealed that the facility's dietitian failed to conduct quarterly monitoring of special/modified diets. The findings include: The GHMRP failed to ensure that Resident #3' nutritional status was monitored quarterly as evidenced below: See Federal Deficiency Report Citation 3502.16	I 058	I 058 Cross refer – I 054	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.	I 090		

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I 090	Continued From page 3 The finding includes: Observations of the GHMRP 's environment on March 13, 2008 beginning at 3:35 PM revealed there was chipping paint and rust observed on the front and back porch rails. Interview with the Qualified Mental Retardation Professional (QMRP) acknowledges that the rails needed to be painted.	I 090	I 090 Front and back porch rails have been painted. In the future the facility will ensure that monthly environment and infection control audits are completed.	4/8/08
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on March 13, 2008 at 11:20 AM, revealed that GHMRP failed to provide evidence of current signed job descriptions for six direct care staff [PW, SN, JA, EO, BN and SA].	I 203	I 203 Job descriptions are reviewed and signed yearly during annual appraisals. In the future the facility QMRP will ensure that all job descriptions are filed in a timely manner.	4/8/08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.	I 206	See attached: job descriptions #6	

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I 206	Continued From page 4 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform their required duties. The finding includes: On March 13, 2008 at approximately 2:00 PM, interview with the QMRP and review of the GHMRP's personnel files revealed the GHMRP failed to provide evidence that current health certificates were on file for two (202 Direct Care Staff [SA and EO], Social Worker, Nutritionist, Podiatrist, Pharmacist and the Speech and Language Consultant.	I 206	I 206 Health certificates are obtained annually for every employee, to ensure their health status would allow them to remain employed. See attached health certificates #7	4/8/08
I 220	3510.1 STAFF TRAINING Each employee who has no previous experience working with individuals with mental retardation shall be required to successfully complete orientation training appropriate to the needs of the residents in the GHMRP. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that new staff received training to ensure the health and well-being of its residents. The finding includes: Interview with the QMRP and a review of the	I 220	I 220 The Agency conducts orientation training for all new employees prior to working at the facility. This training encompasses all DDS and Agency Policies and Procedures. The facility also has a 'New Employee Orientation Manual' which contains specific information about the individuals residing at the facility. In the future the Agency will ensure all new employees attend the orientation training prior to working at the facility. See attached orientation sign record.	4/8/08

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I 220	Continued From page 5 available personel file one (1) direct care staff [LD] failed to evidence a successful completion of orientation training to include agency policy and procedures as well as the facility's practices.	I 220	I 223 The Agency conducts orientation training for all new employees prior to working at the facility. This training encompasses all DDS and Agency Policies and Procedures.	
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on observation and staff interview the GHMRP failed to ensure orientation training for direct care staff was available for review as evidence below. The finding includes: Interview with Residential Manager and review of the in-service training manual on March 14, 2008 revealed there were no training agendas and signature sheets on file for recently hired staff who was working at the facility during the survey.	I 223	The facility also has a 'New Employee Orientation Manual', which contains specific information about the individuals residing at the facility. In the future the Agency will ensure all new employees attend the orientation training prior to working at the facility. See attached orientation sign record.	4/8/08
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview, and record review the GHMRP failed to ensure each clients records were kept current. The finding includes: (See Federal Deficiency Citation W114)	I 291	I 291 The facility has re trained the nurses on Policy and Procedures for Medication Administration. In the future the facility nurse will complete weekly audits of all MARs to ensure P&P of medication administration are being followed. See attached in service record for P&P of Medication Administration	4/8/08

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I 401	Continued From page 6	I 401		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to provided diagnosis, evaluation, treatment services and necessary follow up service to prevent deterioration or further loss of functioning for each resident in the facility. The finding includes: See Federal Deficiency report Citation W220, W289 and W331	I 401	I 401 Cross refer to W 220	
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP's nursing staff failed to ensure medication administration records were maintained without documentation error. The finding includes: See Federal Deficiency Report W365 and W368	I 474	The facility has re trained the nurses on Policy and Procedures for Medication Administration. In the future the facility nurse will complete weekly audits of all MARs to ensure P&P of medication administration are being followed. The Agency RN or DON will also complete quarterly audits on all medical records and MARs. See attached in service record for P&P of Medication Administration	4/8/08

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R 000	INITIAL COMMENTS A licensure survey was conducted from March 12, 2008 through March 14, 2008. A random sample of three clients was selected from a client population of six male clients with varying degrees of disabilities. The survey was completed using the fundamental survey process. The findings of this survey were based on observations at the group home and two day program, interview with day program staff, residential staff, and a review of the habilitation and administrative records to include the review of the facility incident management system.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The finding includes: Review of the personnel records on March 14, 2008 at 12:30 PM revealed that the GHMRP	R 125	R 125 The Agency completes criminal background checks prior to being employed. In the future the facility QMRP will double check copies of all personnel records prior to working with the individuals. See attached #1criminal background check	4/8/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Susan Steinhagen, MA TITLE VP-Operations (X6) DATE 4/3/08

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R 125	Continued From page 1 failed to provide evidence that ensured criminal background checks were on file for one (1) direct care staff (JA).	R 125		

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W 000	INITIAL COMMENTS A recertification survey was conducted from March 12, 2008 through March 14, 2008. A random sample of three clients was selected from a client population of six male clients with varying degrees of disabilities. The survey was completed using the fundamental survey process. The findings of this survey were based on observations at the group home and two day program, interview with day program staff, management and residential staff, and a review of the habilitation and administrative records to include the review of the facility incident management system.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews with direct care staff, and the review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following: The finding includes: I. The governing body failed to have an effective system to ensure the administration and security of medication as evidenced below: A. [Cross Reference W365] The governing body failed to have an effective system of monitoring the administration of client medications in	W 104	W 104 1. A- D The Agency has a Policy and Procedure on Medication Administration. All nursing staff and TMEs were in serviced to ensure that medication administration storage, ordering and documentation procedures are followed. In the future the DON will complete quarterly audits on all medical records and MARs. See attached in service record and medical records audit record.	4/8/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Stocking, RN, MA — TITLE: VP Operations — (X6) DATE: 4/8/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 accordance with the agency's nursing policy on medication administration. B. [Cross Reference W368] The governing body failed to have an effective system of ensure that medications were administered in accordance with physician's orders. C. [Cross Reference W381] The governing body failed to have an effective system to ensure medications were secured until medication administration in accordance with the agency's policy and procedures. D. [Cross Reference W331(4)] The governing body failed to ensure that medication nurse followed the agency policy and procedures on reporting and replacement of spilled medication. II. The governing body failed to ensure that th facility's medication nurse reported and documented spill medication in accordance to the agency's nursing policy and procedure. Observation of the medication pass on March 12, 2008 at approximately 6:00 PM revealed that the medication nurse attempt to administer Client #4's medication regimen. The nurse punched the Client #4's Risperdal 1 mg into the medication cup and crushed the pill. Once completely crushing the medication, the nurse mixed the medication in some jello. Client #4 was waiting, however, he was complaining that he want some applesauce. The medication nurse handed the medication cup to Client #4 with the jello and medication mixture. He immediately once taking the cup dropped the	W 104		

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W 104	Continued From page 2 mixture on the hall floor. The QMRP and the direct care staff assisted the client in cleaning un the spilled medication mixture. The medication nurse was then observed to punch out a pill from the next day (3/13/08) and place the pill in a medication cup and place the cup in the pill crusher. He then instructed Client #4 to crush his pill. The nurse turns to the surveyor to inform him that this was a part of Client #4's self-medication program. Once Client #4 crushed his medication, the nurse took the crusher with the medication cup back from him and the QMRP escorted the provide the client into the kitchen to choose another jello (orange). Client #4 appeared to be very pleased with his selection of the orange jello and the nurse reinforced him and readministered his medication mixed in the orange jello without incident. Interview with the nurse and review of the medication administration record did not evidence that the nurse had reported the spilled medication to the nurse coordinator and /or the Director of Nursing. Interview with the Nursing Coordinator on 3/13/08 revealed that the agency's policy required the nurse to repunch the pill from the bubble pack, document on the MAR and the nursing notes, and contact the Director of Nursing (DON) to account for the pill. According to the Nurse the purpose of communication with the DON is to ensure that the medication was reordered from the pharmacy to replace the spilled medication.	W 104	W 104 11. Cross refer to W 104-1.	
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.	W 114		

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W 114	Continued From page 3 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that entries onto a client's Medication Administration Records were signed and dated for two of three clients included in the sample. (Client #2 and #3) The findings include: On March 12, 2008 at approximately 3:25 PM, interview with the Nurse and review of Client #2 and #3's MAR's [i. e. for the months of August 2007 through February 2008] revealed that MAR's were missing date, initials/signatures and reason in which each client's medication were not administered as prescribed. [See W365]	W 114	W 114 Cross refer to W 104, W 365	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the rights and dignity of all the clients, which reside in the facility. (Client #1,#3 and #6) The findings include: The facility failed to ensure direct care staff ensure each clients' rights to privacy during personal care activities. [See W130]	W 125	W 125 The agency has a Policy on client rights and privacy. Staff was in serviced on this policy. The QMRP and House Manager will closely monitor staff to ensure the individuals have the opportunity to exercise their rights. See attached In service record for client rights and privacy	4/8/08

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W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure and encourage one of the four clients residing in the facility an opportunity to exercise their rights to privacy. (Client #1, #3 and #6) The findings include: The direct care staff failed to ensure each client privacy during activities of daily living as evidenced below: 1. On March 12, 2008 at approximately 5:54 PM the direct care staff encourage Client #1 to go to the bathroom upon his arrival to the facility. The direct care staff only moments later was observed to open the bathroom door without knocking and entered the bathroom while Client #1 was in the bathroom. 2. On March 12, 2008 at approximately 6:08 PM another direct care staff was observed to open the bathroom door without knocking and entered while Client #6 was in the bathroom. It should be noted that Client #3 was observed to enter with the direct care staff. The staff instructed Client #3 to wash his hands while the bathroom door remain open.	W 130	W 130 Cross refer W 125	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS	W 153		

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W 153	Continued From page 5 The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) for one of three clients included in the sample. (Client #1) The finding includes: Interview and review of the unusual incidents on March 13, 2008 at approximately 11:40 AM at the day program revealed an incident report dated October 31, 2007. According to the report, Client #1's day program's Coordinator notice that his hand was bleeding while engaged in table top activity. Interview with the facility's Qualified Mental Retardation Professional on March 14, 2008 at approximately 2:20 PM revealed that QMRP had no knowledge of the unusual incident. According to the QMRP she visit the day program regularly. Review of the unusual incident log book did not evidence that this injury of unknown origin had been reported to the facility's management.	W 153	W 153 The Agency has a policy on Incident reporting and Management. The day program has been given a copy of this and a list of contact numbers to assist in prompt reporting. The QMRP and nurse will continue to visit the day program at least monthly. See attached Incident Management Policy and contact numbers along with the receipt from day program	4/8/08
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be	W 159		

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W 159	Continued From page 6 integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The findings include: The facility's QMRP failed to ensure the coordinator with Client #1, #2 and #3 day program to ensure that their medical records were updated with the current physician orders as evidenced below: 1. On March 13, 2008 at approximately 11:37 AM, interview with the day program's Case Manager/nurse, and review of medical records revealed that the last physicians orders received was September 2007. Interview with the facility's Licensed Practical Nurse (LPN) Coordinator on March 14, 2008 at approximately 2:30 PM revealed that their have been several changes made on Client #1's physicians orders since September 2007. The LPN acknowledges that current physicians had not been forwarded to the day program of Client #1. Interview with the QMRP revealed that she visit the day program regularly and is the person responsible for updating the day program on each client's medical, programmatic and support changes. 2. On March 13, 2008 at approximately 11:00 AM, interview with the day program's Case Manager/nurse, and review of medical records	W 159	W 159 The Agency has a policy on Medication Administration. Physician's orders are signed quarterly and a copy must be submitted to the day program. In the future the nurse will ensure that all POS are forwarded to the day program along with a Day Program communication receipt, which will be filed in the individual's medical record. See attached Day program communication form.	4/8/08

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W 159	Continued From page 7 revealed that the last physicians orders received was November 2007. Interview with the facility's Licensed Practical Nurse (LPN) Coordinator on March 14, 2008 at approximately 2:30 PM revealed that their have been several changes made on Client #2 and #3's physicians orders since November 2007. Further interview with the LPN revealed that she had forwarded the current physicians orders to Client #2 and #3's day program; however, this could not be confirmed through record verification at the day program. Interview with the QMRP revealed that she visit the day program regularly and is the person responsible for updating the day program on each client's medical, programmatic and support changes.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. The findings include: The facility failed to ensure that direct care staff allow each client privacy during activities of daily living. [See W130]	W 189	W 189 Cross refer W 130	
W 220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	W 220		

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W 220	Continued From page 8 include speech and language development. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a speech-language assessment to determine the client's communication needs, for one of the three clients in the sample. (Client #1) The finding includes: Observation on March 12 and 13, 2007 revealed that Client #3 involved in an activity of his choice. The activity was a interactive music game with a selector pen. Further observation revealed that the client was using the pen to select different music tunes. Once selecting the music tune the communication devices would respond and a voice command provide Client #3 with further instruction. As the music played he rock from side to side, smiled and appeared to enjoy the music selection from his interaction with the music tune box. Interview with the QMRP revealed that the client was to have received Speech and Language evaluation. According to the QMRP, the Speech consultant came to the facility to initiate the assessment , however, the consultant had not returned to the facility to complete the assessment process for Client #3. Review of the available Speech and Language assessment dated 3/07/04 the following was recommended: 1. A low technology device with the ability to state the client's personal information. 2. Training on community awareness and safety	W 220	W 220 The Agency's Speech and Language consultant will complete a functional assessment on client#3's communication needs and device. Training will be completed as needed. In the future the facility's QMRP will ensure all assessments are completed in a timely manner. See attached Speech and Language assessment	4/8/08

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W 220	Continued From page 9 survival Review of the habilitation records failed to indicate when this communication device had been purchased and a objective implemented to address his knowledge of his personal information. Review of the program book did not evidence a updated Speech and Language evaluation as a part of the comprehensive functional assessment.	W 220		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure nursing services in accordance with the needs of three of three clients included in the sample. (Client #1, #2 and #3) The findings include: 1. The facility's nursing staff failed to ensure that MAR were maintained. [See W365] 2. The facility's medication nurse failed to ensure that medication were secure until medication administration. [See W381] 3. The facility's medication nurse failed to ensure that medication were administrated as per the physician order. [See W368]	W 331	W 331 Cross refer to W 104	
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client.	W 365		

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W 365	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to establish and maintain a systems that ensures that an individuals medication records were maintained for two of the client's in the sample. (Client #2 and #3) The findings include: The facility failed to ensure an effective system for documenting Client medication administration as evidence by the following: On March 12, 2008 at approximately 5:57 PM review of the facility's Medication Administration Records (MAR's) revealed the following client's medications were given/missed or not documented appropriately. 1. Client #2's prescribed medication included: February 1, 2008 - Depakote Sprinkles 125 mg 5:00 PM dosage February 1, 2008 - Alavert 120-5 mg 5:00 PM dosage February 1, 2008 - Fluoxetine HCL 40 mg 5:00 PM dosage February 1, 2008 - Benztropine Mesylate 1 mg 5:00 PM dosage 2. Client #3's prescribed medication included: August 10, 2007 - Lactulose 10 gm/15 ML	W 365	W 365 Cross refer to W 104	

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W 365	Continued From page 11 Solution 30 ML (20 gm) 5:00 PM dosage October 1, 2007 - Chlorhexidine Gluconate 0.12% Liquid AM and PM treatment dosages	W 365		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered in accordance with physician's orders for one of clients in the sample. (Clients #2) The finding includes: The medication nurse failed to administered Client #2's medication as prescribed by the physician. Observation of the medication pas on March 12, 2008 at approximately 5:47 PM revealed that Client #2 receives Risperdal 1 mg in the evening as a part of his evening medication regimen. Interview with the nurse and a review of the March bubble pack revealed that on March 9, 10, 11, 12, 2008 the evening dosage of Risperdal had not been punched from the bubble pack. Further interview with the nurse revealed that the client may have been on leave from the facility with a family member. A later interview with the nursing coordinator on March 13, 2008 at approximately 3:00 PM	W 368	W 368 Cross refer to W 104	

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W 368	Continued From page 12 revealed that the client had not been on leave. According to the nursing coordinator the agency's policy/protocol required the medication to be ordered from the pharmacy in advance when the client is scheduled for a leave of absence.	W 368		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to store drugs under proper conditions of security. The finding includes: The facility failed to ensure that medications were supervised and secured in accordance with the agency's policy and procedures as evidence by the following: Observation of the medication pass on March 12, 2008 at approximately 5:47 PM revealed that the medication nurse/ house Manager opened the medication closet, left the keys in the door and walked away from the closet. The nurse was observed to enter the bathroom and wash his hand. The nurse was then observed to go to the kitchen. Client #2 was observed to pass the open medication closet while the client medication supply was unsupervised.	W 381	W 381 Cross refer to W 104	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses,	W 436		

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W 436	Continued From page 13 hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure availbility of a client's adaptive equipment for one of three clients in the sample. [Client #3] The finding includes: Observation at the dinner meal on March 12, 2008 at approximately 5:40 PM revealed that Client #3 was eating a from a high sided scoop plate. Day program observation on March 13, 2008 at approximately 12:42 PM , revealed that Resident #3 sitting at the dining room table preparing to eat his lunch. The client meal was severed in a three partician plate. Interview with the QMRP at the group home revealed that client #3 is prescribed a high sided scoop plate at meals to assist him with his independent eating skills. According to the QMRP she purchased the prescribed adaptive plates and personally delivered the adaptive equipment to the day program for the client use during meals. Note: It should be further noted that the direct care staff assigned to table set up for the day program and food dispensing was employed at the client group homes in the evening.	W 436	W 436 Cross refer to I 054	